# INVASIVE GROUP B STREPTOCOCCUS (GBS) - Page 1 of 3

Indiana State Department of Health
State Form 50999 (R/10-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✱
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

## Section 1. Demographic Information

**Last Name** ____ **ISDH Action:** ○ A case ○ Not a case

**First Name** ____ **MI** ____ **Phone Number** ___ - ___ - ____

**Number & Street Address** ____

**City** ____ **State** ____ **ZIP Code** ____ - ____

**County** ____ **Date of Birth** ___ / ___ / ____ **Age** ____

**Race:**
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

**Ethnicity:** ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

**Sex:** ○ Male ○ Female ○ Unknown

**Is Age in day/mo/yr?**
- ○ Days
- ○ Months
- ○ Years

## Section 2. Clinical Information

**Date of Onset** ___ / ___ / ___

**Was the patient hospitalized?** ○ Yes ○ No

**If Yes, admission date:** ___ / ___ / ___

**Discharge date:** ___ / ___ / ___

**Hospital:** ____

**Patient chart number:** ____

**Physician:** ____

**Physician phone:** ___ - ___ - ____

**Outcome:** ○ Survived ○ Died ○ Unknown

**If Died, date:** ___ / ___ / ___

**Is patient diabetic?** ○ Yes ○ No ○ Unknown

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## Section 2. Clinical Information (continued)

**Sterile site from which GBS was isolated (check all that apply):**

- ○ Blood
- ○ CSF
- ○ Pleural Fluid
- ○ Surgical Aspirate
- ○ Other normally sterile site, specify:

**Other site from which GBS was isolated (check all that apply):**

- ○ Placenta
- ○ Amniotic Fluid
- ○ Wound
- ○ Urine
- ○ Other, specify:

**Type of infection caused by GBS (check all that apply):**

- ○ Bacteremia
- ○ Meningitis
- ○ Soft Tissue Infection
- ○ Pneumonia
- ○ Amnionitis
- ○ Bladder Infection
- ○ Other, specify:

## Section 3. Pregnant/Intrapartum

**Was the patient pregnant or intrapartum at the time of the first positive culture?**

○ Yes ○ No ○ Unknown

**If Yes, outcome of fetus:**

- ○ Survived, No Apparent Illness
- ○ Survived, Clinical Infection
- ○ Live Birth/Neonatal Death
- ○ Abortion/Stillbirth
- ○ Induced Abortion
- ○ Unknown

**Did patient receive prenatal care?**

○ Yes ○ No ○ Unknown

**Was penicillin (PCN) or PCN derivative given?**

○ Yes ○ No ○ Unknown

**Was any other antibiotic given?**

○ Yes ○ No ○ Unknown

**If Yes, antibiotic:**

**Was PCN resistance noted?**

○ Yes ○ No ○ Unknown ○ N/A

**Did the patient have any of the following:**

○ GBS Carrier Prenatally ○ Ruptured Membranes for 12 Hours or More ○ Intrapartum Fever

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## Section 4. Infant

**If patient was less than 3 months of age, provide the following birth information:**

**Gestational Age:** ____ **(weeks)** **Weight:** ____ **(grams)** **Mother's Age:** ____

## Section 5. Comments/Follow-up

**Comments:**

**Investigator Name**

**Agency**

**Phone Number** ___ - ___ - ____ **Date** __ / __ / ____